



## No Sex Please, We're...Embarrassed!

Gilleece, T. (2018). No Sex Please, We're...Embarrassed! *Imaging and Therapy Practice*, 19-22.

[Link to publication record in Ulster University Research Portal](#)

**Published in:**  
Imaging and Therapy Practice

**Publication Status:**  
Published (in print/issue): 04/01/2018

**Document Version**  
Author Accepted version

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I have recently had surgery and on the morning of my discharge from hospital, the nurse provided an advice sheet that clearly stated 15 points covering information on a range of topics; wound dressings, removal of stitches, exercising and so forth. She patiently went through each point, expanding further on the information written on the sheet until we arrived at number 13 which she said was self-explanatory. All the points were self-explanatory but number 13 read: 'You can return to normal sexual activity as soon as it feels comfortable'; this obviously caused the nurse some embarrassment, and so she quickly passed it by. Sex is a topic often avoided by healthcare professionals (HCPs), yet one that can be of importance to our patients.

## **Sex**

Sex is the most universal experience. Confucius is credited with the quote: "After people are clothed and fed, then they think about sex."

Social and cultural constraints in many countries have made discussion of sex a taboo ([#1](#)) and it was not until Kinsey established the Institute for Sex Research in 1947, and subsequent work was undertaken by Masters and Johnston in the middle of the 20th century, that some of the veils which modern culture has placed on this subject began to be lifted.

Despite more openness about sex, the inclusion of sex education into the school curriculum and the development of medications such as Viagra, sex remains an area of immense embarrassment to many HCPs, patients and the general public ([#2](#)).

Research into sexual activity has, for the most part, consisted of assessment of the mechanical aspects. However, Cleary & Hegarty ([#3](#)) defined their 'Neo-theoretical Framework of Sexuality' that is more encompassing and moves beyond the coital imperative to include the human need for intimacy.

## **Cancer and chronic illness as a barrier to sexual relationships**

Cancer Research UK (2012) estimates that 54% of the male population and 48% of the female population in the UK will develop cancer. From a positive perspective, medical knowledge, along with improved treatment and earlier diagnosis, means that there are currently more than two million cancer survivors living in the UK. Cancer is now viewed as a chronic illness. Despite the long-term survival rates, it is unlikely that the survivor's life will return to the pre-diagnosis state for a variety of reasons, including side-effects of treatment, decreased physical functioning, fear of recurrence, fatigue and bodily changes.

In Maslow's 'Hierarchy of Needs', preserving life will obviously be of greatest importance but sex is listed in the first stage and the World Health Organisation (WHO) views sexuality as an integral component of the human experience.

Whilst it is logical that cancers which affect sexual and reproductive organs can result in problems relating to sexual intimacy, it has been shown that a cancer diagnosis in other organs: colon, bladder, lymphatic and head and neck areas, can result in a reduction in sexual interest and activity [\(#4\)](#) [\(#5\)](#).

The reasons for this are numerous: the actual cancer can cause physiological changes that disrupt sexual function, eg testes, vagina, prostate, pituitary, that in themselves may curtail sexual intimacy. However, cancers anywhere in the body can result in symptoms of pain, immobility, fatigue or reduced physical stamina [\(#6\)](#). The treatment can cause scarring, loss of function or toxicities that result in additional pain, erythema, peripheral neuropathies, vomiting and diarrhoea, amongst other things. Medications can cause side effects that reduce libido, increase weight, or change body shape. All of these can result in sexual dysfunction.

Consider, in addition to the physiological factors, the psychological elements that accompany diagnosis and treatment for life threatening conditions. Anxiety, depression, fears of recurrence, loss of control and self-confidence, loss of earnings, worry about partners' reactions and changes to oneself [\(#7\)](#) [\(#8\)](#), all have an enormous bearing on our patients. The practicalities of dealing with a major health problem can result in gender role conflict.

## **Sensitive issues**

Despite living in a modern society where sexual equality is seen as a basic right, evolution still has an impact and social expectations continue to play

a part in gender identity. Being forced to step away from social norms can cause distress. Ill health can require a change in gender roles. For females, this may mean relinquishing a caring role within the family, handing household duties to others, losing a sense of purpose if infertility is a side effect of treatment. For males, gender identity is tied to their role as a provider and protector. The social norm is to restrict emotions and place a high importance on sexual performance.

For partners in a relationship with a person diagnosed with cancer, the issue of sexual activity can be particularly difficult to negotiate. They can be fearful of initiating intercourse through concern that it may seem trivial, selfish or uncaring. Their reluctance can appear to the person with cancer as an indication that their treatment has rendered them unattractive, undesirable and unwanted ([#9](#)) ([#10](#)).

Increased emphasis on the quality of life (QoL) of those surviving cancer has resulted in a growing body of literature on QoL issues. A number of aspects of QoL are now commonly addressed but sexual expression and intimacy is still often ignored

## **Age**

Cancer is largely a disease of older people, and this is reflected in Cancer Research UK's statistics which show the majority of cancers occurring in people over 70 years old. The stereotypical view of older people as asexual beings pervades, coupled with the view that longevity is more important than QoL, and therefore loss of sexual intimacy may be an acceptable side effect of treatments. This may be true for some individuals and literature does show that couples in longer term relationships cope better with both the physical and psychosexual changes that result from cancer treatments ([#11](#)). But although it is indisputable that sexual function does decline to some extent in most people with increasing age, it does not mean that we all face a life devoid of intimacy in our later years ([#12](#)) ([#13](#)) ([#14](#)). It would be wrong to assume that patients do not require information and help with preserving their physical relationships.

Worryingly, the same statistics identify that in 2012-2014, the largest increase in the diagnosis of cancer has been in people aged 0-24, with a 20% increase between 1993-1995 and 2012-2014. This is a continuation of the trend since the 1980s ([#15](#)). Successful treatment in a younger age group would appear to create additional difficulties from the perspective that often this age group must negotiate new relationships. Interestingly, studies by both Vermeer et al ([#16](#)) and Izycki et al ([#9](#)) found that partners who started a relationship after treatment for cancer, experienced less

sexual stress. Perhaps the younger age group are more adept at identifying the necessary resources to promote their quality of life.

## **Health-care professionals and sex**

Sexual problems associated with ill health can be escalated by HCPs. Healthcare professionals avoid discussing topics relating to sex whenever possible and rarely elude to it unless addressing the biophysical aspects, such as infertility, contraception, or advice on menopausal issues ([#17](#)). Literature shows they consider sexual relationships to be a private matter, they are embarrassed by the subject, are concerned about causing offence, or their own religious views and/or preconceptions, mean that they find the idea of older people having sexual relations repugnant ([#18](#)).

Hordern and Street ([#19](#)) found that there were mismatched expectations and unmet needs when they conducted interviews with 50 people with cancer and 32 HCPs. The HCPs believed they were addressing patient sexuality and intimacy needs when they spoke to patients about related infertility, menopause, erectile dysfunction, loss of libido and contraceptive requirements. The HCPs assumed that patients would share their one dimensional focus of combating the disease. It is known that patients with a cancer diagnosis will prefer to focus on issues of survival in the initial stages of disease, but this does not mean that sexual functionality is not important to them in the longer term([#20](#)).

An unexpected finding of Horden & Street's study was the level of vulnerability expressed by the HCPs about discussing such issues. Litten-Olesen et al similarly found that even by 2015, only a quarter of doctors discussed sexuality with patients who were recovering from cancer.

The vulnerability of the patients must be acknowledged too, and people may choose not to disclose facts that demonstrate their loss of virility. Tsvian et al ([#21](#)) found discrepancy between the level of medication for erectile dysfunction reported by men (32%) and the number reported by their wives as using medications to improve erections (85%). There will always be those for whom matters of intimacy are a private issue.

## **Conclusion**

The Framework for Sexual Health Improvement (FSH) in England ([#22](#)) acknowledges that there is considerable evidence that cancer impacts on people's sexual health in a negative way, and cancer survivorship services need to reflect this.

Patients are very aware of the time restraints within the healthcare system and often adjust their expectations because of the brevity of the follow-up. Therapeutic radiographers have the opportunity to build a stronger relationship with patients, but training for radiographers in addressing the subject of sex and sexual problems with our patients is extremely limited, if not fully absent. Tierney shows that if the sexual relationship with a partner is strained, the recovery process may be threatened ([#23](#)). As HCPs, we have a duty of care to ensure all of our patients' problems are given equal consideration to promote the best possible chance of long-term recovery and optimal quality of life.

## About the Author

Terri Gilleece is a Lecturer at The School of Health Sciences, Ulster University.

## How to use this article for CPD

- Why do you think healthcare professionals are so reticent to discuss sex with patients?
- Do we believe that anyone with an illness is no longer interested in sex? If so, why is that?
- What type of training is needed to overcome embarrassment when discussing sex with our service-users?
- When should such training be undertaken?
- QA Code: 569DD623 ([Figure #1](#))

## REFERENCES

<http://www.sor.org//learning/library-publications/itp>

This article has been prepared following local guidance relating to the use of patient data and medical images.

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The aim of the article is to highlight the necessity for radiographers to consider the service user's need for guidance on intimate and sexual activity during and after treatment.

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